State of West Virginia ★ Public Employees Insurance Agency **Health Benefits Enrollment Form**

HEALTH

Complete this form to enroll for health coverage. Complete all sections of the form except "AGENCY."

	Name (Last)	(First) (MI) (Generation: Jr., Sr., etc.) Social Security Number						г			
	Street Address						County of Residence Home Phone				
(EE	City	Sta	ate		Zip			Job Title		Work Phone	
EMPLOYEE	Sex (Circle One) Date of Birth (mm/dd/yyyy) Other Insurance (Plan Name) If Any M F										
EN	Do you wish	to participate in th	ne IRS S	ection 12	5 Premium Co	nversio	ı Plan	sponsored	by PEIA, it	f available? YES	NO
		ticipate in the hea		rage.	alth coverage, p	lease si	gn thi	s box and r	eturn this fo	orm to your benefit Date:	coordinator. I
	Is spouse curre	ntly insured by PEL			?□Yes □No	If yes, e	nter sp	ouse's Socia	al Security N		
	Please comple	te the following inf	ormation		0.00	vill be c	vered	l under you	r plan:	1	
	Last, F	Name irst, MI, Generation))		Address rent from above)		onship e One)	Sex/ Category	Birth Date	Social Security Number	Other Insurance (Plan Name)
NOL						SP	СН		2		
INFORMATION						SP	СН				
						SP	СН				
FAMILY						SP	СН				
FA						SP	СН		ė		
	Court-Ordere gender and re	ed Dependent Child elationship code (e	1 5. Studeng, M1	dent (age for Male	19-25) 6. Othe Child; F3 for F	r In de Temale	epend Frand	ent column child; F25	titled "Sex for Female	Step-child 3. Grand Category", please Step-child/Student gal guardianship	e include both , etc.). <i>If adding a</i>
3E	COVERAGE enrolling for:	SELECTION (Se	elect One) I am	Please indicate the plan option				are enrolling	by checking the b	ox beside
COVERAGE		mployee Only			1 PEIA PPB Plan A 4 The Health Plan HMC				MO Plan A		
00	7.00	mployee/Child(rer amily	1) Only		2 PEIA PPB Plan B 5 The Health Plan HMO Plan PEIA PPB Plan C					MO Plan B	
_		amily with Employ	· •				2020000	<i>77</i> -	he form. If r	none of the people	enrolled on your
	PEIA covera	age uses tobacco, y	you will	receive t	he discount on	your he	alth ar	nd life insu	rance premi	iums I acknowledg	e by signing the
AVITS	Acceptance box below that WVPEIA or its agents have access to my medical records to check my tobacco use status. Who uses tobacco: Policyholder Dependent (spouse and/or children)										
AFFIDA		☐ No Tobacco Users within the last six (6) months ving Will Affidavit: PEIA offers a premium discount to health policyholders who have executed a Living Will/Advance Directive. rou have a valid living will, please check the box beside the statement below and sign the form.									
	☐ By chec		knowled	lge that I	have executed	a valid	Living	g Will or ac	lvance direc	tive, and that I hav	re discussed its
NCE	I hereby acc	ept the group cove of contribution. I	erage I h	ave indic	ated above. I us	nderstar n is tru	nd tha e and	t the PEIA	may change l understand	the types or level that providing fal	se information
ACCEPTANCE	dependents, process clai	to the release to F	EIA and erage, re	to the p	lan I have selec lization, investi	ted, of a	ill me nplair	dical and p	rescription quality of ca	onsent, for myself drug information r ire, evaluate plan p	eeded to
AC	Employee's Sig			•				Date:			
_	To Be Completed Agency Name	By The Employer:				Account	Number		Date of Emplo	yment	
2	Hours Worked Wee	kly	Effective F	ate of Cover	age	Index Co		Region	Coverage Cod	58	
AGENCY	I hereby certify tha	t, to the best of my knowle	edge, the int	ormation co	ntained herein is accu					ent full-time employee of t	his agency who meets
	Authorized Signature			oyees Insur	ance Plan.				1	Date	w000 142.55 :
DIC	oce cond only	the original to Pl	EΙΛ								Revised December 15, 2010

Health Benefits Enrollment Form

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit number found on the monthly billing invoice.

Date of Employment: Date Employee was hired or the date he or she became benefit-eligible.

Hours Worked Weekly: Number of hours the employee works each week.

Effective date of Coverage: When completing the form, enter the first day of the month following date of enrollment (the date the employee signs the forms to elect the coverage). Remember that the employee must be actively at work for coverage to begin. If the employee is not actively at work on the day coverage would have begun, then the effective date of coverage is delayed until the employee is actively at work.

Index Code: Choose the code from the appropriate chart below to reflects the employee's annual salary.

	For State Agencies, Colleges, Universities and County Boards of Education For the PEIA PPB Plan A and ALL managed care coverages						
	Salary						
Index Code	From	То					
01	\$ 0	\$ 20,000					
02	\$ 20,001	\$ 30,000					
03	\$ 30,001	\$ 36,000					
04	\$ 36,001	\$ 42,000					
05	\$ 42,001	\$ 50,000					
06	\$ 50,001	\$ 62,500					
07	\$ 62,501	\$ 75,000					
08	\$ 75,001	\$100,000					
09	\$100,001	\$125,000					
10	\$125,001	and over					
04	Legislature						

PEIA PPB Plan B		Salary
Index Code	From	То
01	\$ 0	\$ 20,000
02	\$ 20,001	\$ 30,000
03	\$ 30,001	\$ 36,000
04	\$ 36,001	\$ 42,000
05	\$ 42,001	\$ 50,000
06	\$ 50,001	\$ 62,500
07	\$ 62,501	\$ 75,000
08	\$ 75,001	\$100,000
09	\$100,001	\$125,000
10	\$125,001	and over
04	Legislature	

Forms 2 December 2010

For Non-State Agencies				
Plan	Option Code			
PEIA PPB Plan A	004			
PEIA PPB Plan B	010			

Region: Leave blank. No longer used.

Coverage Code: Please use one of the codes below to indicate which plan the policyholder chose:

HI01 PEIA PPB Plan A
HI02 PEIA PPB Plan B
HI03 PEIA PPB Plan C
HMHP - A Health Plan HMO Plan A

HMHP - A Health Plan HMO Plan A
HMHP - B Health Plan HMO Plan B

Enter one of the following letters beside the Coverage Code to show the tier of coverage the employee has selected:

P = Policyholder Only

F = Policyholder, Spouse and Children

C = Policyholder and Children Only

S = Policyholder and Spouse Only (generates same premium as F)

Please note: There is no coverage code for Family with Employee Spouse (ESPS). It is coded as F or S, and the eligibility system assigns the ESPS premium. If the addition of health coverage creates as ESPS situation, PEIA needs to be aware of the IDX change if applicable so that it may be made at time of entry into the PEIA system. PEIA does not have access to salaries.

A completed Coverage code could look like this: **HI01** – **P**, or like this: **HMHP-B-F**.

Please note that if documentation is required for a dependent and cannot be submitted with the enrollment application, the form on page 9 should accompany submission of the documentation to PEIA.

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you sign the form. Forms should be signed immediately upon receipt from the policyholder.

Forms 3 December 2010

State of West Virginia ★ Public Employees Insurance Agency Basic Life Insurance Enrollment Form

BASIC LIFE

	Complete this form to enroll for PEIA basic life insurance coverage. Complete all sections of the form except the last section, "AGENCY", and return it to your benefit coordinator.								
	Name (Last) (First)	(MI)	4	(Genera	tion: Jr., Sr., etc.) Social	Security Number	900		
EE	Street Address		County of Residence Home Phone						
EMPLOYEE	City State Zip	itle		~	Work Pho	one)			
EM	Sex (Circle One) Date of Birth (mm/de	d/yyyy)					gn this box and return in any PEIA coverage.		
ARY	Please designate the beneficiary(ies) of this will be distributed equally among all designate beneficiaries, the share of any beneficiary will beneficiaries. If no beneficiary survives the the beneficiary should be fully spelled out, a	ited beneficiar ho predecease employee, pay	e insurance ries unless of s the emplo ment will b	otherwise indic eyee will be dis se made in acco	cated. If unequal pated if unequal pateributed equally a cordance with the t	percentages a nmong all sur- terms of the part. A. Doe".	are assigned to the rviving named policy. The name of		
BENEFICIARY	Beneficiary Name (Last, First, MI, Generation)	Beneficiary Ad	dress (Street,	City, State, Zip)	Social Security#	Relationship To Insured	Distribution % Total must equal 100%		
BEN									
COVERAGE	The Basic Life Insurance offered by PEIA is age. Here are the policy values for Active en Emplo Emplo	decreasing ter	m coverage e 65 ut under 70	~		of life insura	ince decreases as you		
	Tobacco Affidavit								
AFFIDAVIT	Please mark which members of the family use tobacco and sign the acceptance box below. If none of the people enrolled on your PEIA coverage uses tobacco, you will receive the discount on your PEIA PPB Plan health coverage (if any) and optional life insurance premiums. I acknowledge by signing the Acceptance box below that WVPEIA or its agents have access to my medical records to check my tobacco use status. Who uses tobacco: Policyholder Dependent (spouse and/or children) No Tobacco Users within the last six (6) months						optional life ss to my medical		
ACCEPTANCE	I hereby accept the basic life insurance. I understand that the PEIA may change the types or levels of benefits or the amount of contribution. I certify that the above information is true and correct and understand that providing false information on this form is illegal and that those who provide false information may be prosecuted.								
	Employee Signature:			Date:					
	To Be Completed By The Employer: Agency Name		Account	Number	Date of Employme	nt	-		
(CY	Hours Worked Weekly Effective Date of Coverage	Index Code	0.0000000000000000000000000000000000000	Region	Coverage Code	*****			
AGENCY	,		aikilieni		100				
200	I hereby certify that this information is true and this applicant me Authorized Signature:	eis ine inmimum eli	gionny requiren	nents for the Public E	imployees Insurance Plan Date	·			

WHITE - PEIA CANARY - Payroll Location PINK - Employee Revised July 2004

Forms 4 December 2010

Basic Life Insurance Enrollment Form

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Date of Employment: Date Employee was hired or the date he or she became benefit-eligible.

Hours Worked Weekly: Number of hours the employee works each week.

Effective date of Coverage: When completing the form, enter the first day of the month following date of enrollment (the date the employee signs the forms and returns it to you to elect the coverage), if it is within the month of hire and the two following calendar months. If an employee elects coverage outside this period, the employee must complete an evidence of insurability application; PEIA and Minnesota Life, the life insurance carrier, will determine the effective date of coverage. We will contact you when the medical underwriting decision has been made. Remember that the employee must be actively at work for coverage to begin. If the employee is not actively at work due to illness or injury on the day coverage would have begun, then the effective date of coverage is delayed until the employee is actively at work.

Index Code: Index Code: Choose the code from the appropriate chart on Page 2 that reflects the employee's annual salary.

Region: Not necessary on the Basic Life form.

Coverage Code: Mark with code LB01 for basic life.

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you sign the form. Forms should be signed immediately upon receipt from the policyholder.

Forms 5 December 2010

State of West Virginia • Public Employees Insurance Agency Change-In-Status Form

Change in Status

Comp	lete this form to change the status of your cover	age. Complete all sections as appropriate	except	the sec	tions "AGENO	CY" and "PEIA" a	nd return to your benefit o	oordinator.	
П	Name (Last) (First)	(MI)	V-5		(Generat	ion: Jr., Sr., etc.)	Social Security Number		
Æ.	Street Address Check if New Address				County	of Residence	Home Phone	7	
EMPLOYEE	City State	Zip			Job Titl	le	() Work Phone		
EM		VV. (()		
	Do you participate in the IRS Sec	tion 125 Premium Conversion F	Plan s	ponso	ored by PE	EIA, if availab	le? YES	NO NO	
\Box	Please indicate the type of status change				(First)	(C		MI/Gen)	
		billing from Employer Account #						thin the same agency	
Æ		our choice(s):					Plan 1 Plan 2	Plan 3 Plan 4	
띪		Mark your choice(s): Health n (Requires PEIA approval if outside ope			pendent Optio	onal Life Insurance	е		
CHANGE TYPE	From: (Plan Name)		_	To: (Pla	an Name)	20-0 -	- JIII Dian I BAO Dian A	T Lie alle Des LINO Dies D	
		k only one) PEIA PPB Plan A PB					- Company of the Comp	Hearn Man HWO Man B	
	008 Tobacco status change				CHA MOSECOCI				
П		000000 0000000 NOO 10 AV		onship	Sex/		Social Security Number	Other Insurance	
	Name (Last, First, MI, Generation)	Address (If different from above)	_	e One)	Category	Birth Date		(Plan Name)	
_			SP	СН					
E N			SP	СН					
END			SP	СН					
DEP	E.								
			SP	СН					
	CATEGORY for Dependent Child(ren): Re 19-25) 6. Other In dependent column titled								
	Step-child/Student, etc.). If adding a depend dependent upon the member for financial su	ent child other than your biological or add							
\vdash				eserces.					
	Policyholder must provide documentation for every type of status change.								
=	1 Marriage 5	Death of spouse or dependent			9	full-time stu	of dependent child due to ag udent status	070 #200	
A S ON	2 Divorce 6	Beginning or end of spouse's employment		10101040	10	Change fro employee	im full-time to part-time empli or spouse	syment or vice-versa for	
RE/	3 Birth of Child 7	Significant change in health coverage d employment			11	Open Enro			
	4 Adoption 8	Unpaid leave of absence by employee			12		se specify):		
	Leeftly that on/ (date of event) I incurred the status change marked above, and I, therefore, wish to change my plan benefits as indicated. I understand that the change requested must be consistent with the event. I further understand that I am required to maintain documentation of this event, and I may be requested to provide this documentation to the WV Public Employees Insurance Agency, my employer, or the Internal Revenue Service for Section 125 purposes.								
H		200 A		disease	111			11	
BRA	Under Federal COBRA law, PEIA must offe with the necessary applications by Acordia N If dependent's address is different than the	lational, who administers COBRA for the I	PEIA. Y	ou will	have a limited				
00	if dependent's address is different than the	policynoider's address, please provide the	aepen	dents a	adress nere:				
IN	Tobacco Affidavit You must complete this affidavit. Please mark which members of the family use tobacco and sign the affidavit. If none of the people enrolled on your PEIA coverage uses tobacco,								
FIDA	you will receive the discount on your health	and life insurance premiums; to receive the	e disco	unt, ple	ease mark the	No Tobacco Use			
ш.	signing the Acceptance box below that WVPEIA or its agents have access to my medical records to check my tobacco use status.								
A	Who uses tobacco: Policyholder	Dependent (spouse and/or ch	liaren)		☐ NO 1 ODS	acco Users Within	the last six (6) months		
ш	I hereby accept the changes to my group co that the changes I have made may affect m								
ACCEPTANCE	illegal and that those who provide false info selected, of all medical and prescription dru	mation may be prosecuted. I hereby cons	ent, fo	myself	f and my cove	red dependents, t	to the release to PEIA and	to the plan I have	
EPT	plan performance or any other process invo					unicutori, invocagi	ato complanto, acceso qu	and of our of overall	
ACC									
	Employee's Signature:				Date:				
Α	To Be Completed By The Employer: Agency Name Agency Adency Adenc	dress (Include City, State and Zip Code)							
Ğ	Account Number Index Co		LD			NEW	Effective Da	ite of This Status Change	
N	I hereby certify that, to the best of my knowledge,	the information contained herein is accurate. If	_	ertify that	t the employee is	100,000,000	me employee of this agency	who meets the minimum	
Y	eligibility requirements for the Public Employees Authorized Signature:	nsurance Plan.					Date:		
Р	To Be Completed By The Public Employees Ins	urance Agency:					and the		
E	For purposes of the Premium Conversion Plan, th	is family status change has been:							
1.1	Approved Denied Denied	Pended for Further Information			uthorized PEIA	Cionaturo		Date:	

Please submit only the original to PEIA

Forms

6

Change - In - Status Form

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit number found on the monthly billing invoice.

Index Code: Choose the code from the appropriate chart below to reflects the employee's annual salary.

	For State Agencies, Colleges, Universities and County Boards of Education For the PEIA PPB Plans A & B and ALL managed care coverages				
		Salary			
Index Code	From	To			
01	\$ 0	\$ 20,000			
02	\$ 20,001	\$ 30,000			
03	\$ 30,001	\$ 36,000			
04	\$ 36,001	\$ 42,000			
05	\$ 42,001	\$ 50,000			
06	\$ 50,001	\$ 62,500			
07	\$ 62,501	\$ 75,000			
08	\$ 75,001	\$100,000			
09	\$100,001	\$125,000			
10	\$125,001	and over			
04	Legislature				

For Non-State Agencies				
Plan Option Code				
PEIA PPB Plan A	004			
PEIA PPB Plan B	010			

Coverage Code (old and new): Please use one of the codes below to indicate which plan the policyholder is moving from and which plan the policyholder is moving to:

HI01	PEIA PPB Plan A
HI02	PEIA PPB Plan B
HI03	PEIA PPB Plan C
НМНР - А	Health Plan HMO Pl

HMHP - A Health Plan HMO Plan A HMHP - B Health Plan HMO Plan B

Enter one of the following letters beside the Coverage Code to show the tier of coverage the employee has selected:

P = Policyholder Only

F = Policyholder, Spouse and Children

C = Policyholder and Children Only

S = Policyholder and Spouse Only (generates same premium as F)

Forms 7 December 2010

Please note: There is no coverage code for Family with Employee Spouse (ESPS). It is coded as F or S, and the eligibility system assigns the ESPS premium. If the addition of health coverage creates as ESPS situation, PEIA needs to be aware of the IDX change if applicable so that it may be made at time of entry into the PEIA system. PEIA does not have access to salaries.

A completed Coverage code could look like this: **HI01 – P**, or like this: **HMHP-B-F**.

Effective Date of This Status Change: Typically this date is the 1st day of the following month the employee has signed to elect the change. For example, if the Change in Status is dated Jan 28, 2010, by the employee, the effective date would be 2-1-2010.

In the case of a newborn or adopted child, the effective date may be retroactive. For **newborns** added within the month of birth and the two following calendar months effective date of coverage is the date of the child's birth. For **adopted children** if added within the month of adoption or the following two calendar months, the effective date of coverage is retroactive to the date the child was placed in the home or the date the policyholder became financially responsible for the adopted child.

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you signed the form. Forms should be signed immediately upon receipt from the policyholder.

Remember that all changes require documentation, and no changes can be made outside Open Enrollment without a qualifying event. If you cannot submit the documentation with the Change in Status form, the form on the following page should accompany submission of documentation to PEIA.

Forms 8 December 2010

MEMO



To:	PEIA Eligibility Documentation Unit	
From:	(policyholder's name) Date:	
Re:	Unique ID number	OR
	Last four digits of SSN	

Please mark the type of transaction you're documenting and the documentation attached.

Status Change Event	Documentation Required			
New Hire	If adding spouse to coverage, copy of valid marriage license or certificate. If adding children, see "birth of child," "adoption" or "adding coverage for a child" below for documents required.			
Divorce	Provide a copy of the divorce decree showing that the divorce is final. The ex-spouse is not eligible for coverage a of the end of the month in which the divorce became final.			
Marriage	Copy of valid marriage license or certificate			
Birth of Child	Copy of child's birth certificate			
Adoption	Copy of adoption papers			
Adding coverage for a child who resides with the policyholder and for whom the policyholder is 100% financially responsible	Court-ordered guardianship papers.			
Open Enrollment under spouse's employer's benefit plan	A copy of printed material showing open enrollment dates and the employer's name.			
Death of spouse or dependent	A copy of the death certificate.			
Beginning of spouse's employment	A letter from the spouse's employer stating the hire date, effective date of insurance, what coverage was added, and what dependents are covered.			
End of spouse's employment	A letter from the spouse's employer stating the termination or retirement date, what coverage was lost, and dependent that were covered.			
Unpaid leave of absence by employee or spouse	A letter from your or your spouse's personnel office stating the date that you or your spouse went on unpaid leave or returned from unpaid leave.			
Significant Change in Health Coverage Attributable to Spouse's Employment	A letter from the spouse's insurance carrier indicating the change in insurance coverage, the effective date of that change and dependents covered.			
Ineligibility of dependent child due to age	Copy of the dependent's birth certificate			
Change from full-time to part-time employment or vice versa for employee or spouse	A letter from your or your spouse's employer stating the previous hours worked and the new hours worked and the effective date of the change.			

Please send this cover sheet with your documents to the address below.

601 57^{th} Street, SE • Suite 2 • Charleston, WV 25304-2345 An equal opportunity employer.

9 December 2010 Forms

State of West Virginia Public Employees Insurance Agency Policyholder Termination Of Coverage Form

TERM

Revised July 2004

	Complete this form to terminate your health and/or optional life insurance coverage. Please complete all sections as appropriate except the last section ("AGENCY") and return to your benefit coordinator.								
П	Name (Last)	(First)	(MI)	(Generation: Jr., Sr., etc) Social Security N	umber			
OYEE	Street Address			County of Residence	Home Phone				
EMPLOYEE	City	State	Zip	Job Title	Work Phone				
	Is spouse currently insured	by PEIA as a policyholder? 🔲 Ye	es 🛮 No If YES, pro	vide spouse's Social Security Num	ber (SSN):				
TERMINATION REASON	Check Appropriate Box: Ooi								
APPEAL	Policyholder Signature In the case of a termina with your employer's appayroll, as long as you a		have the right to an adr ur coverage for 3 MON' ee's share" of the month	ent. Please refer to your Sum ninistrative appeal. If an adm PHS after the end of the mont ly premium. If you lose the ap	Date: Date: inistrative appeal h in which you ar opeal, and have el	is to be instituted, re removed from the lected to continue			
ADMINISTRATIVE APPEAL	your coverage. Please mark your choice: I elect to continue coverage during the administrative appeal, realizing fully that if my appeal is lost, I am responsible for reimbursing the entire premium to the agency or to the State of West Virginia. I decline to continue coverage during the administrative appeal.								
COBRA	Policyholder Signature: Under Federal COBRA law, PEIA and the managed care plans must offer continued coverage to qualified policyholders or dependents under certain circumstances. You will be sent a notification with the necessary applications by Acordia National, the company which administers COBRA for PEIA. You will have a limited amount of time to elect continuation of coverage. COBRA premiums include both the employer and employee share of the premium, as well as an administrative fee, so they are higher than premiums paid by active employees. The premiums are printed in the Shopper's Guide each year. For further information, you may contact Acordia National at 1-888-440-7342.								
П	To Be Completed By The Agency Name	Effective Date of Term	ination Account Number	Date Off P	ayroll	Current Coverage Code			
AGENCY	I hereby certify that, to the bes	st of my knowledge, the information co	ontained herein is accurate.						
	Authorized Signature:				Date:				
	WHITE - PEIA	YELLOW - PEIA for MCO	PINK - Payroll	Location GOLDE	NROD - Employee	Revised July 2004			

10 Forms December 2010

Policyholder Termination of Coverage Form

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit number found on the monthly billing invoice.

Effective Date of Termination: This date should be the last day of the calendar month in which the employee's coverage ends. If an employee went off payroll January 1st, the effective date of termination would be January 31st. In the event an employee's last paycheck would not cover the PEIA health premium, and the employee chooses not to pay the premium, please indicate the last month for which the employee paid premiums. In the case where the dates are not within the same month, please provide details in the "other please explain" section.

Date Off Payroll: The last day the employee is on payroll.

Current Coverage Code: Indicate the Code of Coverage under which the employee was last covered.

HI01 PEIA PPB Plan A HI02 PEIA PPB Plan B HI03 PEIA PPB Plan C

HMHP - A Health Plan HMO Plan A HMHP - B Health Plan HMO Plan B LB01 Life Insurance Only

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you signed the form. Forms should be signed immediately upon receipt from the policyholder.

Forms 11 December 2010

State of West Virginia Public Employees Insurance Agency

Health Benefits and Life Insurance Change-In-Address Form



Revised January 2004

Complete this form to advise PEIA of a change in address. Please complete all sections as appropriate except the last section, "AGENCY", and return to your payroll coordinator.

E	Name (Last)		(First)	(M	I)	(Generation)		Social :	Security	Number
M P	OLD ADDRESS	Street				County of R	Lesidence	Home P	hone	1
L O Y	City State					Zip		Work Phone		
E E	Indicate Coverages Health Basic Life	☐ Opti	urrently Active onal Life ional Dependent Life						A-1	
C H T	NEW ADDRESS O	OF POLICYH	OLDER Street			County of R	esi dence	Home P	hone	
AY NP	City State					Zip		Work Pl	none	
G E E	Effective Date of N	ew Address	Employee's Signa	ture					2	
	Name		Address		onship	Sex/Category	Birth Date	\$000 CM & MOVE	Days Miller N.	Effective Date
	(Last, First, MI, Ge	eneration)	(If different from above)	(Circl SP	e One) CH	M/F	(mm/dd/yy)	Social Sec	urity#	of New Address
D E P				SP	СН					
E N				SP	СН					
D E N T	CATEGORY for I 1. Child (biological 2. Step-child	or adopted)	3. Grande	Ordere	-	dent Child	6. Oth		20	d/Student etc.)
									sup cim	wistered in the state of the st
A G E	To Be Comple Agency Name	ted By The	e Employer:	Ageno	y Addre	ss (Include City, Sta	ate and Zip Code)		Region	ı
E N C	Account Number		Authorized Signature:				19	Date:		
1	WHITE - PEIA	VELLOV	V - Managed Care Plan	PT	NK - Pa	roll Location	COLDENE	OD - Employe	ρ	PEIA - 4005

Forms 12 December 2010

Health Benefits and Life Insurance Change - In - Address Form

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Agency Address: Your agency address.

Region: No longer required on the Change in Address form.

Account Number: Your 9-digit agency account number as it appears on your billing.

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you signed the form. Forms should be signed immediately upon receipt from the policyholder.

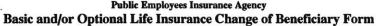
Forms 13 December 2010

State of West Virginia

Public Employees Insurance Agency

Complete this form to update or change the distribution of your insurance benefits.

Complete all sections of the form except the last section, "AGENCY".





Name (Last)	0				1 1	
Sex (Circle One)	Male	Female	Date of Birth (MM/DD/YY)		Work Phone	
Street Address	•	City	State	Zip Code	Home Phone	
Please change the Please change the If more than one benefici	e beneficiary(s) of e beneficiary(s) of e beneficiary(s) of iary is named, you will be paid in equal predeceases the em	f my Optional Lift f both my Basi u may divide the d all shares to the na nployee will be dis	asurance. Complete Section A fe Insurance. Complete Section ic and Optional Life Insuran leath benefit by noting what per med beneficiaries who survive stributed equally among all surv	n B below. nce. Complete Section A and reentage is to be paid to each b the employee. If unequal percent	Section B below. eneficiary after his/her na	e beneficiario
SECTION A BASIC I Please designate the bene "Mrs. John Doe" or "Mrs	eficiary(s) of your		F BENEFICIARY name of the coverage below. The name of	of the beneficiary should be ful	ly spelled out, and writte	n "Jane B. De
	eneficiary Name First, Middle Init		Relationship to the Insured	(5	Address ddress, City, State, Zip Co	.4.
(====						
				*		
Please designate the bene	eficiary(s) of your		GE OF BENEFICIARY name of coverage below. The name of	of the beneficiary should be fu	lly spelled out, and writte	en "Jane B. D
Please designate the bene "Mrs. John Doe" or "Mrs. B	eficiary(s) of your	r basic life insuran			lly spelled out, and writte Address ddress, City, State, Zip C	
Please designate the bene "Mrs. John Doe" or "Mrs. B	eficiary(s) of your s. J. A. Doe". Seneficiary Name	r basic life insuran	Relationship		Address	
Please designate the bene "Mrs. John Doe" or "Mrs. B	eficiary(s) of your s. J. A. Doe". Seneficiary Name	r basic life insuran	Relationship		Address	
Please designate the bene "Mrs. John Doe" or "Mrs. B	eficiary(s) of your s. J. A. Doe". Seneficiary Name	r basic life insuran	Relationship		Address	
Please designate the bene "Mrs. John Doe" or "Mrs. B (Last,	eficiary(s) of your s. J. A. Doe". Reneficiary Name J. First, Middle Init	r basic life insuran	Relationship	(Street A	Address ddress, City, State, Zip C	ode)
Please designate the bene "Mrs. John Doe" or "Mrs. B (Last,	eficiary(s) of your s. J. A. Doe". deneficiary Name print, Middle Init	r basic life insuran	Relationship to the Insured	(Street A	Address ddress, City, State, Zip C	ode)
Please designate the bene "Mrs. John Doe" or "Mrs. B (Last,	eficiary(s) of your s. J. A. Doe". deneficiary Name print, Middle Init	r basic life insuran	Relationship to the Insured	(Street A	Address ddress, City, State, Zip C	ode)
Please designate the bene "Mrs. John Doe" or "Mrs. B (Last, I wish to make the char Employee's Signature _	eficiary(s) of your s. J. A. Doe". deneficiary Name print, Middle Init	r basic life insuran	Relationship to the Insured	(Street A	Address ddress, City, State, Zip C	ode)
Please designate the bene "Mrs. John Doe" or "Mrs. B (Last, I wish to make the char Employee's Signature _	eficiary(s) of your s. J. A. Doe". deneficiary Name print, Middle Init	r basic life insuran	Relationship to the Insured that I may, at a future date, of	(Street A	Address ddress, City, State, Zip C	ode)
Please designate the bene "Mrs. John Doe" or "Mrs. B (Last, I wish to make the char Employee's Signature Witness' Signature	eficiary(s) of your s. J. A. Doe". deneficiary Name print, Middle Init	r basic life insuran	Relationship to the Insured that I may, at a future date, of	than a beneficiary.)	Address ddress, City, State, Zip C	ode)
Please designate the bene "Mrs. John Doe" or "Mrs. B (Last, I wish to make the char Employee's Signature Witness' Signature Agency Name	eficiary(s) of your s. J. A. Doe". deneficiary Name print, Middle Init	r basic life insuran	Relationship to the Insured that I may, at a future date, of	than a beneficiary.)	Address ddress, City, State, Zip C	ode)

14 December 2010 Forms

Basic and/or Optional Life Insurance Change of Beneficiary Form

You do not need to complete the Agency section of this form. All of the Employee information is required, but we no longer require the Benefit Coordinator to complete or sign this form.

Forms 15 December 2010

State of West Virginia Public Employees Insurance Agency Optional Life Insurance and Dependent Life Insurance Enrollment Form

OPT

Complete this form to enroll for or increase optional and/or dependent life insurance coverage. Complete all sections of the form except the one titled "AGENCY," which must be completed by the benefit coordinator at your place of employment. Return the completed form to your benefit coordinator. Do not mail it to PEIA.

	Name (Last)				(M)	!			Social Security	Number
	Gender (check one)	Male	☐ Female	Ė	Date of Birth (MM	I/DD/YYYY)			Work Phone	
E	Street Address	Ç	ity		State		Zip Code		Home Phone	
	Optional Life Insuran coverage is based on yo delayed until you are ac for coverage, check the	ur selection and ; tively at work. (your age on the eff loverage of more t	fective date of c than Plan X requ	overage. You must aires that you compl	be actively at we	ork on the date or	werage become	s effective; otherv	rise coverage will be
M	Entiployee's Age Under age 65 Age 65 to 69 Age 70 and above	Plan I \$5,000 3,250 2,250	Pinn III \$10,000 6,500 4,500	Plan III \$20,000 13,000 9,000	© Plan IV \$30,000 19,500 13,500	Plan V \$40,000 26,000 18,000	Plan VI \$50,000 32,500 22,500	Plan Viii \$60,000 39,000 27,000	\$75,00 48,75	0 \$80,000 0 52,000
	Employee's Age Under age 65 Age 65 to 69 Age 70 and above	Plan X \$100,000 65,000 45,000	Plan XI \$150,000 97,500 67,500	Plan XII \$200,000 130,000 90,000	Plan XHI \$250,000 162,500 112,500	EPlan XIV \$300,000 195,000 135,000	Plan XV \$350,000 227,500 157,500	Plan XV \$400,00 260,00 180,00	0 \$450,00 0 292,50	0 \$500,000 0 325,000
P	Please designate the ber Doe" or "Mrs. J.A. Doe Beneficiary Nas	." You may char	nge your beneficia	urance coverage ry at any time b	y filing a Change of	t of the beneficiar Beneficiary for to the Insured	y should be fully m with PEIA.			Doe," not "Mrs. John ity, State, Zip Code)
	1)		1							· · · · · · · · · · · · · · · · · · ·
_	2)									
L	3)									
	4)									
	If more than one beneficiar equal shares to the named b among all surviving named	eneficiaries who su	vive the employee. I	f unequal percents	iges are assigned to the	beneficiaries, the sl	hare of any benefici	e above. If no per ary who prodeces	centage is noted, the ses the employee will	death benefit will be paid in be distributed equally
\mathbf{O}	Dependent Life Insure	nee – You may	hoose to enroll fo	r dependent life	and accidental deat	h and dismember	rment insurance	or your spouse	and/or children. 1	he beneficiary of the
	To enroll for dependent complete the following	life insurance, m		ur choice and	Plan II \$16	000 for each chil	ld ouse and		n IV – \$20,000 fo	each child
Y	Dependent N (Last, first, middle		Social Securit	y Number	Date of (MM/DD/	Birth	R	elationship		Date Eligible* (MM/DD/YY)
							Wife Daughter		Husband Son	
							Daughter		Son	
17							Daughter		Son	
\mathbf{E}				 			Daughter Other	specify below	Son	
	*Date of Marriage or A **Must be eligible depe	doption, if applie ardent according	able. To add a dej to PEIA rules. Se	pendent to your e your PEJA Su	health coverage, yo mmary Plan Descrie	u must complete prion for details.	a Change-In-Sta	us form.	ı	
E	Selection, Acceptance, Optional Life in You must mark ONE	surance of the following: e been explained	Dependent Life I statements: to me, and I decli	insurance (spour	se and/or child)					
	The benefits have earnings until re Employee's Signature	voked by me in v	vriting. I understa	nd that the PEL	rms of group covers A may change the ty	ge indicated abor pes or levels of b	ve, and authorize benefits or the am	deduction of m wunt of contrib	y premium contril ution. Date	oution from my
A G	Agency Name		D. Di		In the		Account Numb			
E N	OPT Plan		Dep Plan		Date of Employm		Effective Date		100	
C Y	I hereby certify that the Authorized Signature	information above	e is true to the bes	t of my knowle	dge, and that the em	ployee is eligible	e for coverage un	der PEIA.	Date	
	WHITE PEIA		PINK P	ayroli Location	COL	D Enrollee		PEIA 1010		Nevember 2002

16 December 2010 Forms

Revised Nevember 2002

Optional and Dependent Life Insurance Enrollment Form (OPT)

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit agency account number as it appears on your billing.

OPT Plan: Use the option code below based on the plan chosen by the employee.

Active Employee Plan Number	Option Code
Plan I	100
Plan II	200
Plan III	300
Plan IV	400
Plan V	500
Plan VI	600
Plan VII	650
Plan VIII	700
Plan IX	750
Plan X	800
Plan XI	900
Plan XII	950
Plan XIII	951
Plan XIV	952
Plan XV	953
Plan XVI	954
Plan XVII	955
Plan XVIII	956

If an employee chooses more than \$100,000 of coverage, he or she will be required to complete an Evidence of Insurability Application form.

Dep. Plan: Use the option code below based on the plan chosen by the employee.

Dependent Plan Number	Option Code
1	100
2	200
3	300
4	400

Please note that if documentation is required for a dependent and cannot be submitted with the Optional and Dependent Life Insurance Enrollment form, the form on page 9 should accompany submission of the documentation to PEIA.

Date of Employment: Date of full-time employment for the employee with your agency.

Effective Date of Coverage: When completing the form, enter the first day of the month following date of enrollment (the date the employee signs the form and returns it to you to elect the coverage), as long as it is within the month of hire and the two following calendar months. If an employee elects coverage outside this period, the employee must complete an evidence of insurability application; PEIA and Minnesota Life, the life insurance carrier, will determine the effective date of coverage. We will contact you when the medical underwriting decision has been made. Remember that the employee must be actively at work for coverage (or an increase in the amount of coverage) to begin. If the employee is not actively at work on the day coverage would have begun, then the effective date of coverage is delayed until the employee is actively at work.

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you signed the form. Forms should be signed immediately upon receipt from the policyholder.

Forms 18 December 2010

MINNESOTA LIFE

GROUP LIFE INSURANCE EVIDENCE OF INSURABILITY

Minnesota Life	e Insurance	Company • 4	00 Trac	y Way • Sulte 100	 Charlestor 	WV 25	311 • Fax	304-344-1221			
POLICYHO	LDER: PE	IA					POLICY	NUMBER: 3	3227		
EMPLOYER	INFORMA	TION - (to be	e comp	leted by Benefit (
EMPLOYER NA	WE				ACCOUNT	NUMBER		DATE OF EMPLOYMENT/ EMPLOYEE STATUS			
							11.21112111		ACTIVE [_ RETIRE) EMPLOYEE
FIRST NAME	INFORMA		C1 E INI	Tiel	LACTNAME			TEMAN ADDDO	.00		
FIRST NAME		MIL	OLE INI	HAL	LAST NAME			EMAIL ADDRE	:55		
STREET ADDR	E.88.				İCITY		STATE	ZIP CODE	EME	LOYEE ID	
OTTECT ADDIT					[l in a	2.11 0002		LOILL ID	
NAME	OF ALL	RELATION	ISHIP/	SOCIAL SECUR	ITY CUB	RENT	NEW TO	TAL PLAN	DATE OF		* DATE
	PLICANTS	COVER/		NUMBER		MOUNT	AMOUN			GENDER	ELIGIBLE
		Employ	/ee						+		
		Basic I Employ									
		Optional	life								
		Spous Optional	e Liffe								
		Child	1								
		Optional	III0						+		
*Date of ma	arriage or a	adoption, if a	applica	able.							
HEALTH Q	_		прриоч								
		ı	EMPL	OYEE		SPOUS	E				
YES NO	SPOUSE YES NO	YES NO	HEIGH	IT WE	IGHT	HEIGHT	Г	WEIGHT	OCCUPATIO	N	
			1. Dur	ing the past three	years, have	you for	any reaso	on consulted	a physician(s	or other	health
				e provider(s), or b							
				ve you ever had, o vous system, or r							umor:
			dru	g or alcohol abus	e including a	ddiction	?				
			3. Hav	ve you ever been tem; or tested po	diagnosed a	s having	g AIDS, AF	RC, or any dis	sorder of your	immune	J.
If you answe	eryes to an	y question, g	ive det	tails including dat itment in the Addi	es, names a itional Health	nd addr	esses of d	octors or hos	pitals, the res	ason fort	he visit
sheet of pap		girosio, and d	ne trea	turierit ili ule Audi	nioriai i rearu	i iiiioiiiik	ation occu	or or the sec	ond page of	orra ocqu	arate
AUTHORIZ	ATION										
The answer	s provided	on this appli	cation	are representation	ons of the pe	rson sic	aning belo	w.The answ	ers given are	true and	
complete. It	is understo	od that Minr	nesota	Life Insurance C	ompany, (th	e Comp	any), St. F	Paul, Minneso	ota 55101-20	98 shall i	incur no
				and until it is ap ility are as descri							
				f coverage. If cov							
				urposes, Lauthori:							
				any medical or no said sources, ex							
				rmation. I underst							
be made ava	ailable to un	nderwriting, c	laims,	medical and supp	port staff of t	he Com	pany. If I c	lo not revoke	this authoriza	ation, it w	ill be
				A photocopy shall age and I unders				ave read this	Authorization	n and the	1
Concanori	mady mon	00 011 010 001	ona p	age and randers	ocario a accerto	ar reave	оорюс.				
EMPLOYEE SK	GNATURE				DAYTIME TEL	EPHONE	NUMBER E	VENING TELEP	HONE NUMBER	DATE SI	GNED
X						4-115-21-2					SUES
SPOUSE SIGN	ATURE				LIAY TIME TEL	EPHONE	NUMBER E	VENING TELEP	HUNE NUMBER	DATE SI	GNED
X 03-30567.47					<u> </u>					EdEgagan	Rev 8-2008
										Edi 04040	

Forms 19 December 2010

Evidence of Insurability Application for Coverage

Employer Information – The benefit coordinator completes this section.

Employer name – The agency name as it appears on your PEIA monthly billing

Account number – The agency account number from your PEIA monthly billing

Date of employment/retirement – The employee's hire date or date the employee retired

Employee status – Mark whether an Active or Retired Employee

Stop. The rest of the form is for the employee to complete.

The employee only needs to complete the Spouse and Child information if he or she is applying for dependent life coverage.

The Evidence of Insurability Application must be mailed to Minnesota Life with the Basic or Optional Life and Dependent Life Insurance Enrollment Form.

Forms 20 December 2010

Notice of Death

Minnesota Life Insurance Company - A Securian Company • Refer completed Claims to:
Public Employee Insurance Agency • Capital Complex • Building 5, 10th floor • Charleston, WV 25305-0710
Toll free 1-888-680-7342



. Employee name (last, first, mid			complet	ed by th	ne employ	er)		Park Art	2. Employ	ee Social Security number	
B. Employee address (street, city,	state, z	ip)	+						4. Employ	ee telephone number	
5. Employee date of hire (mo/day	/yr)		6. Effect	tive date of employee's insurance (mo/day/yr)					7. Employee actively at work on effective date?		
PART 2 - DECEASED INFOR . Name of deceased	MATIO	N (to be	2. Decea	ed by the	ne employe	er) number	3. Re	lationship to e	mployee	4. Gender	
. If dependent, effective (mo/day/yr) 6. Date of dependent's insurance?			of birth (m	io/day/yr)	7. Date	of dea	th (mo/day/yr)		as death due to an accident		
PART 3 - EMPLOYER'S CER	TIFICA	TION	300 54		4/6/24						
. Name of employer, association	or fund								2. Telepho	one number)	
Address of employer, association	on or fur	nd (street, o	ity, state,	zip)					4. Accour	nt number	
Signature of authorized represent	tative				Date	signed			Title		
PART 4 - BENEFICIARY STA											
. Print name of beneficiary (last,					A STATE OF THE PARTY OF THE PAR	MACHINE AND REAL PROPERTY AND	alternation resources	Registeration of the Control of the	Market Street St	en known, if any	
. Relationship to deceased	4. Be	neficiary's	Social Sec	curity nur	nber 5. Ber	neficiary's	date o	f birth	6. Benefi	ciary's telephone number	
. Beneficiary's address (street, c	ity, state	, zip)									
Beneficiary's signature									Date		
CERTIFICATION INSTRUCTION CONTINUES TO SERTIFICATION — Under per 1) The number shown on the 2) I am not subject to backup withhol subject to backup withhol 3) I am a U. S. person (included)	of under nalties of is form p withh ding as ding, a	reporting of perjury, is my corr olding eith a result o	interest I certify ect Soci ner beca if a failur	or divide that: al Secu use I ha e to repo	ends on you rity number we not bee	or Taxpa	urn. ayer Id by th	dentification r	number, a	nd Prvice (IRS) that I am	
Certification Notice: THE IF TAXPAYER IDENTIFICATION BACKUP WITHHOLDING FO	RS REC	QUIRES U BER. WITH	S TO OF	STAIN C	ORMATION	, YOU M					
Beneficiary's signature									Date		
X PART 5 - PEIA CERTIFICATI											
nformation provided above is	true and			t of my i							
Employer/policyholder name PEIA		2. Covera	ge code		3. Plan/pol 33227	cy numbe	er 4.	(mo/day/yr)	n premiums	were paid for deceased	
5. Amount of insurance Basic \$	Op	tional \$			Depend	ent \$			Total \$		
Signature of authorized PEIA rep	resenta	tive			Date signe				Telephone number		
For your protection, state	ment o	a loss is	quilty o	f a crim	e and may	be subi	ect to	fines and co	onfineme	nt in state prison. Any	
fraudulent claim for the payi insurance company or agen to a settlement or award pa	it of an	insurance om insur	e compa ance pro	any who	knowingly shall be re	attemp ported to	ts to c	Division of h	nsurance	r or claimant with rega	

Forms 21 December 2010

Notice of Death

You complete Part 4 – Employer's Certification

- 1. Name of employer, association or fund: Your agency name as it appears on your PEIA monthly billing.
- 2. **Telephone Number:** Enter your work phone number.
- 3. Address of employer, association or fund: Enter your agency's mailing address.
- 4. **Account number:** Enter the agency account number from your PEIA monthly billing
- 5. **Signature of authorized representative:** Sign here.
- 6. **Date signed:** The date you signed the form. Forms should be signed immediately upon receipt.
- 7. **Title:** Enter your job title.

You may also need to fill in some information at the top of the form, such as, in Part 1, boxes 9, 10 and 11 -- the employee's date of hire, the effective date of the employee's insurance, and verification of actively at work. And in Part 3, boxes 7, 8 and 9 -- the effective date of the dependent's insurance, verification of premium payment, and the amount of coverage.

Forms 22 December 2010

Waiver of Premium Claim Employer's Statement



MINNESOTA LIFE

Policyholder's name PEIA			Policy number 33227	Branch code	Coverage code			
Insured employee's name (last, first	st, middle initial)		Employee ID	Gender Male				
Street address								
Date of birth (mo/day/yr)		Date employed (mo/day/	yr)	Social Security number				
Job title		Date last worked						
Status on employment date	☐ Full time	☐ Part time	If part-time, average ho	ours per week.				

Minnesota Life Insurance Company - A Securian Company • Claims
Charleston Branch Office • PO Box 3742 • Charleston, WV 25337-3742 • Toll free 1-800-203-9515

Amount of Employee's Insurance
Basic \$ ______

EMPLOYER CERTIFICATION: The undersigned certifies that above statements as to the employee are correct as reported on its records.

Name of employer

Employer's address

Authorized signature
X

F53421-PEIA Rev 10-2010

For your protection, state laws require the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. Any insurance company or agent of an insurance company who knowingly attempts to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.

Waiver of Premium Claim

(Disability Waiver of Premium)

If you have an employee applying for a disability waiver of premium, the Employer's Statement must be completed by you.

Type of Claim: Mark whether the policyholder is an active employee or a retiree.

Account number: Enter the agency account number from your PEIA monthly billing

Coverage Code: Mark with code LB01 for basic life. The premium can only be waived for the basic life

insurance. Premiums must be paid by the policyholder for any optional coverage to keep it in force.

Insured employee's name: Enter the policyholder's full name.

Employee ID: Enter the policyholder's social security number.

Gender: Indicate the gender of the policyholder.

Street Address: Enter the policyholder's home address.

Date of Birth: Enter the policyholder's date of birth.

Date Employed: Date of full-time employment for the employee with your agency.

Social Security Number: Enter the policyholder's social security number.

Job Title: Enter the job title of the policyholder.

Date last worked: Indicate the last date that the employee was actively at work on a full-time basis.

Status on employment date: Indicate whether the employee was full-time or part time.

Amount of Employee's insurance: Fill in the amount of basic life insurance on the employee and the effective

date of coverage.

Employer Certification:

Name of Employer: Your agency name as it appears on your PEIA monthly billing.

Telephone Number: Enter your work phone number.

Address: Enter your agency's mailing address

Authorized Signature: Your signature as the Benefit Coordinator

Date: The date you signed the form. Forms should be signed immediately upon receipt.

When the form is completed, submit it to WVPEIA, State Capitol Complex, Bldg. 5, Rm. 1001, 1900 Kanawha

Blvd. E, Charleston, WV 25305-0710.

Forms 24 December 2010

State of West Virginia ★ Public Employees Insurance Agency Retirement Health Benefits and Basic Life Insurance Enrollment Form



Please read and follow the instructions on the back of this form when completing it. Use this form to enroll for PEIA health and basic life insurance coverage as a retiree. You must complete this form to continue your benefits as a retiree. Complete all sections of the form except the last section, "AGENCY", and return the completed form to your benefit coordinator.

	Name (Last) (First	.)	(MI)	(Ge	neration: Jr., S	Sr., etc) S	ocial Securit	y Number		
RETIREE	Street Address			Cou	nty of Resider	nce	Home Ph	one		
RET	City	S	State		Zip		Work Pho	ne		
	Date of Birth (mm/dd/yyyyy) Sex		I decline partic	ipation i	n any health o	r life insur	ance coverage	e.		
님	1) Were you recently covered by any		Signature		eat three (2) m		Date	□ No		
		-								
	Plan Name						e:			
LION	2) Provide the date when you were or	when you will be	e entitled to M	edicare o	coverage. Effe	ective Date				
RMA.	3) Complete the following information	on for all depende	nts who will be	e covere	d under your p	lan. (Inclu	de Medicare	under Other Insurance)		
NFO	Name (Last, First, MI, Generation)	Address (if different from abo		ionship e One)	Sex/Category (see instruction on back of form)	Birth Date (mm/dd/yyyy	Social Secu Number			
ILY I		(ii diiivi viio Iroiii doo	SP	СН	back of form)			(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
FAMILY INFORMATION			31	CH						
			SP	СН	_					
			SP	СН						
IRY	Beneficiary Name		Beneficiary A		Sac		the Insured	Distribution % (Total Must Equal 100%)		
FICE	(Last, First, MI, Generation)) ((Street, City, S	tate, Zip		mber	the Histiet	(Total Must Equal 10070)		
BENI										
LIFE										
BASIC LIFE BENEFICIARY										
	DEDUCTION AUTHORITY									
	COVERAGE SELECTION (Select One) I am enrolling for:	(Sick an	D EXTENDED E d/or Annual Leav					uity deduction for any		
E	Policyholder Only Health and Life (speci	e if you have sick I choose to use my					ım beginning er my earned extended			
COVERAGE	Family Health and Life (specify plan)		Loutherine enputty deduction for any							
COVI	<u> </u>	P	Extend my employer-paid insurance overage. Please be aware that if the policyholder dies while using this benefit, survivors may continue credit for insurance.							
	Life Insurance Only (NO health benefits)	co	coverage, but may not use any remaining accrued leave. I DO NOT authorize annuity deductions.							
	Life Insurance Only (health benefits under spo		Increase my annuity amount (Complete proper forms from CPRB) request that my coverage terminate at the end of my earned extended coverage.							
ī	Tobacco Affidavit	(ic) + 1	1 1 1		1 1 1	TC	11 1	DELA		
VFFIDAVIT	Mark which members of the family (uses tobacco, you will receive a disc	ount on your PEI	A PPB Plan he	alth cov	erage (if any)	and option	al life insura	nce premiums. I		
FFID.	acknowledge by signing the Accepta	ince box below th	nat WVPEIA of	r its ager	nts have access	s to my me	dical records	to check my tobacco		
Y	Who uses tobacco: Policyholde	er 🗆 Depender	nt (spouse and	or child	ren) 🛮 No '	Γobacco U	sers within th	ne last six (6) months		
Π	I hereby accept the group coverage I hav									
ACCEPTANCE	contribution, and that the choices I have providing false information on this form	is illegal and that t	hose who provid	le false in	formation may	be prosecute	ed. I hereby co	nsent, for myself and		
CEPT	my covered dependents, to the release to process claims, determine coverage, revi involved in my treatment, payment of cl	iew utilization, inve	estigate complair							
AC		aims or nearth care	operations.							
\sqsubseteq	Signature: To Be Completed By The Employer:				Date:					
	Agency Name		Active Account Num		Retiree Accoun	2	Coverage			
	Last Date of Active Employment		Effective Date of Re	etirement		Effective	Date of Retiree In	surance Coverage		
AGENCY	and annual leave for which the coverage	er of months of earned ex ge (2 days = 1 month sin	gle;	3-1/3 years	service = 1 year sin	gle coverage		Total WV State Government credited years of service:		
AGF	employment ceased: Partial	= 1 month family covera months are not allowed.		years of ex	vice = 1 year family tended coverage (in	months):				
	I hereby certify that, to the best of my knowledge, the Employees Insurance Plan.	information contained h	herein is accurate. I fi	urther certif	that the applicant n	neets the minim	um eligibility req	airements for the Public		
	Authorized Signature:			-	1220 1200 - 1210 1210 1210 1	Date				
	WHITE - PEIA GREEN - Managed	Care CANA	RY - Payroll Locatio	n	PINK - CPRB	GOLDEN	ROD · Employee	Revised November 2004		

Forms 25 December 2010

Instructions for Retirement Health Benefits and Basic Life Insurance Enrollment Form

Please follow these instructions carefully when completing this form.

RETIREE

Complete ALL demographic information. The "Generation" area provides a space for men to indicate family generation indicators such as Jr., Sr., II, III, IV, etc.

If you <u>do not</u> wish to enroll for health or life insurance coverage as a retiree, sign and date the box stating "I decline participation ..." and return the form to your benefit coordinator.

FAMILY INFORMATION

1) Please give us information about health insurance that you had during the last three months of your active employment.

If you are currently in the PEIA PPB Plan or one of the managed care plans offered by PEIA, please write in the name of the plan you're in; you do not need to include a termination date.

If you had coverage from another insurer, in the space provided, please write in the plan name and termination date, and attach a certificate of creditable coverage from the other insurer to this form.

- 2) We need information about Medicare coverage for you. Your premium decreases when you are retired and have Medicare. Please provide the date when you were or will become eligible for Medicare (typically age 65, unless you have a disability). When you become eligible for Medicare, it is important that you enroll for both Medicare Parts A and B. Please see your Summary Plan Description for more information.
- 3) We need to know about any dependents to be covered under your health insurance. Please complete the chart. In column titled "Sex/Category", include gender and relationship code (e.g., M1 for Male Child; F3 for Female Grandchild; F25 for Female Step-child/Student, etc.). The relationship codes are:

1. Child (biological or adopted)
4. Court-Ordered Dependent Child

2. Step-child 5. Student(age19-25)

3. Grandchild 6. Other

If adding a dependent child other than your biological or adopted child, notarized documentation is required showing that the child is completely dependent upon the policyholder for financial support.

BENEFICIARY

Your health insurance includes a basic decreasing term life insurance policy on you. Please designate the beneficiary(s) of this basic term life insurance policy in the "Basic Life Insurance Beneficiary" section. Please consult your insurance coordinator if you have questions about the amount of life insurance coverage you have. The life insurance proceeds will be distributed equally among all designated beneficiaries unless you specify otherwise on this form. If unequal percentages are assigned to the beneficiaries, the share of any beneficiary who dies before the policyholder will be distributed equally among all surviving named beneficiaries. If no beneficiary survives the employee, payment will be made in accordance with the terms of the policy. The name of the beneficiary should be written "Jane B. Doe," not "Mrs. John Doe" or "Mrs. J. A. Doe."

COVERAGE

Coverage Selection: Please indicate the type of coverage you choose to have in retirement. Remember that if you are continuing your health care coverage into retirement, you must remain the health care plan you were in as an active employee through the end of the plan year (June 30), unless you were in a managed care plan and will be Medicare-eligible when you retire. Please be sure to fully specify the plan you want, including the plan name and any option, such as PEIA PPB Plan A or The Health Plan Plan B. For life insurance, on this form, you can continue your basic life insurance. If you wish to continue Optional and/or Dependent coverage, you must complete the Retiree Optional Life Insurance form.

Earned Extended Benefits: If you have sick and/or annual leave credits, you must specify how you want to use those credits. You may use them to extend your employer-paid coverage under PEIA or to increase your annuity from CPRB. If you have been in the Plan since before July 1, 1988, your accrued leave days will pay 100% of your monthly premium. If you came into the Plan after July 1, 1988, but before July 1, 2001, your accrued leave days will pay 50% of your monthly premium. For details, please see your Summary Plan Description. If you were hired after July 1, 2001, you cannot use sick/annual leave credits to extend employer-paid insurance coverage.

<u>Deduction Authority:</u> Please indicate how you will pay your premiums by checking the appropriate box.

AFFIDAVIT

PEIA offers discounts to tobacco-free plan members for both health and optional life insurance. You must complete the affidavit to qualify for the discounts.

ACCEPTANCE

When you have made your selections on this form, you must sign and date the "Acceptance" box.

COMPLETING THE PROCESS

When your form is complete, return it to the benefit coordinator at your place of employment (or to the Consolidated Public Retirement Board, if you are already retired). Your benefit coordinator will complete the Agency portion of the form and submit it for processing.

Public Employees Retirement Health Benefits and Basic Life Insurance Enrollment Form (PERS)

Complete the Agency information at the bottom of the form.

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit number found on the monthly billing invoice.

Retiree Account Number: Leave blank.

Coverage Code: Please use one of the codes below to indicate which plan the policyholder chose:

HI01 PEIA PPB Plan A

HMHP - A Health Plan HMO Plan A HMHP - B Health Plan HMO Plan B

Remember that PEIA PPB Plan B is not available to retired employees, and that only NON-MEDICARE retirees are eligible for the managed care plans.

Enter one of the following letters beside the Coverage Code to show the tier of coverage the employee has selected:

P = Policyholder Only

F = Policyholder, Spouse and Children

C = Policyholder and Children Only

S = Policyholder and Spouse Only

Please note: There is no coverage code for Family with Employee Spouse (ESPS). It is coded as F or S, and the eligibility system assigns the ESPS premium. ESPS is based on the active member's salary, and they only receive ESPS if the active member carries health coverage,

A completed Coverage code could look like this: **HI01 – P,** or like this: **HMHP-B-F.**

Option: Choose from the following option codes for the coverage selected.

Retiree Option Codes						
Non-Medicare Retiree (Plan A or managed care only)	011					
Medicare Retiree	012					

Last Date of Active Employment: The last day the employee is on payroll.

Effective Date of Retirement: Enter the effective date of the employee's retirement

Effective Date of Coverage: Usually the same as the effective date of retirement. Coverage for retirees is continuous as long as forms are completed and signed during the retirement event enrollment period.

Number of days of accrued sick and annual leave for which the employee was not paid when employment ceased: complete this if the employee elected to extend employer-paid insurance coverage.

Number of earned extended insurance coverage: calculate the months of extended coverage if the employee elected to extend employer-paid insurance coverage.

Higher Education Extension (Teaching Service): complete if applicable. Please be sure to calculate the total to MONTHS of coverage. See page 18 of the Eligibility section.

Total WV State Government credited years of service: Leave blank.

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you sign the form. Forms should be signed immediately upon receipt from the policyholder.

Forms 28 December 2010

State of West Virginia Public Employees Insurance Agency Retired Employee's Optional and Dependent Life Insurance Enrollment Form



		(First)		(MI)	(Generation) Se	ocial Security	Number
ex (Mark One)	Male	☐ Female	Date of Birth (mn	n/dd/yyyy)		W	ork Phone	
treet Address	City		State		Zip Code	н	ome Phone	
optional Life Insurance -I that you have as an active on heck the box beside the am	employee, you must	complete and attach						
Retiree's Age Under age 65 Age 65 to 69 Age 70 and above	Plan 1 \$5,000 3,250 2,500		Plan II \$10,000 6,500 5,000	Plan : \$15,0 9,7 7,5	00	Plan IV \$20,000 13,000 10,000		\$30,000 19,500 15,000
Retiree's Age Under age 65 Age 65 to 69 Age 70 and above	Plan VI \$40,000 26,000 20,000		Plan VII \$50,000 32,500 25,000	Plan V \$75,0 48,7 37,5	00 50	Plan IX \$100,000 65,000 50,000		Plan X \$150,000 97,500 75,000
Please designate the benefi PEIA. The name of the ber							g a form with	
Benefici	ary Name Middle Initial)	Rel	lationship he Insured	Social Securit			Address ess, City, State	. Zip Cod
(1134, 1134, 1	munic munic	100	не шѕш ец					
)		_						
)								
)								
990								
Dependent Life Insurance policy is the employee. If y approved by the life insuran o enroll for dependent life	you choose a plan hi nce carrier. To enro	igher than what you h ill, check the box besi	ave as an active e	mployee, you mu	st complete and att urance you desire.	ach a Medical I	Information Fo	rm, and be
nd complete the following in		•	Plan II	\$10,000 for you \$ 4,000 for each	spouse	☐ Plan	IV \$ 20,000	
			500000000000000000000000000000000000000	CONTRACTOR CONTRACTOR				
Dependent Name (Last, First, Middle Init	ial) Social	Security Number		of Birth dd/yyyy)		lationship		Date Elig (mm/dd/y
	ial) Social	Security Number		of Birth	Re Wife	1	Husband	
	ial) Social	Security Number		of Birth	Re			
	Social Social	Security Number		of Birth	Wife Daughter Daughter Daughter	1 3 3	Husband Son Son	
(Last, First, Middle Init	131)		(mm	of Birth dd/yyyy)	Re Wife Daughter Daughter Daughter Daughter Daughter Other s	pecify below**	Husband Son Son Son Son	
	poption, if applicable, ent according to PEI reduction Authority ance Depen Following statements even explained to me, een explained to me, ed by me in writing.	To add a dependent I.A rules. See your PF - I am enrolling for () ident Life Insurance (s s;	to your health cov IIA Summary Pla Mark all that appl pouse and/or child	erage, you must on Description for	Re Wife Daughter Daughter Daughter Daughter Other sy omplete a Change- details. Specify rel	pecify below** In-Status formationship:	Husband Son Son Son Non Non Non Non Non Non Non Non Non N	(mm/dd/y
*Date of Marriage or Ade *Must be eligible depende election, Acceptance and D Optional Life Insurou must mark ONE of the I The benefits have be earnings until revok	poption, if applicable, ent according to PEI reduction Authority ance Depen Following statements even explained to me, een explained to me, ed by me in writing.	To add a dependent I A rules. See your PE - I am enrolling for (I dent Life Insurance (s s: and I decline to partici and I hereby accept th I understand that the I	to your health covered	erage, you must on Description for y):) overage indicated the types or levels	Re Wife Daughter Daughter Daughter Daughter Other sy omplete a Change- details. Specify rel	pecify below** In-Status formationship:	Husband Son Son Son Non Non Non Non Non Non Non Non Non N	(mm/dd/y
*Date of Marriage or Ade *Must be eligible depende election, Acceptance and D Optional Life Insurou must mark ONE of the I The benefits have be earnings until revok	poption, if applicable, ent according to PEI reduction Authority ance	To add a dependent I LA rules. See your PE - I am enrolling for () dent Life Insurance (s s: and I decline to particiand I hereby accept th I understand that the I runderstand that the I runderstand that the I runderstand I hereby accept the I understand that the I runderstand that I runderstand that I runderstand that I runderstand that I runderstand I runder	to your health cover to your health cover he	erage, you must on Description for the above into one who prove	Rec Wife Daughter Daughter Daughter Daughter Other sy omplete a Change- details. Specify rel davit. If none insurance prer No tobac ges before the e orm that WVPF ormation is tru de false inform	In-Status formationship: In-Status formationship: Date of the peopliniums. co users in: ffective dat ELA or its age and correctation may be	Husband Son Son Son Son Husband Husban	on your months months and constand ad.
*Date of Marriage or Ade *Must be eligible depende election, Acceptance and D	poption, if applicable, ent according to PEI reduction Authority ance Depen following statements seen explained to me, end by me in writing. The properties of the stobacco you were policy holds formation is correctly and the properties of such change to check my to information on re:	To add a dependent I LA rules. See your PE - I am enrolling for () dent Life Insurance (s s: and I decline to particiand I hereby accept th I understand that the I runderstand that the I runderstand that the I runderstand I hereby accept the I understand that the I runderstand that I runderstand that I runderstand that I runderstand that I runderstand I runder	to your health cover to your health cover he	erage, you must on Description for the above into one who prove	Re Wife Daughter Daughter Daughter Daughter Other sy complete a Change-details. Specify rel above, and authorize of benefits or the am davit. If none insurance prer No tobace ges before the e comment of the work of the system.	pecify below** In-Status formationship: Date of the people in the peo	Husband Son Son Son Ny premium con ution. et the last six te of my cov gents have a et and under be prosecute	on your months months and constand ad.
*Date of Marriage or Ade *Must be eligible depende election, Acceptance and D Optional Life Insur- ou must mark ONE of the I The benefits have be earnings until revok Retired Employee's Signate Please mark which i PEIA coverage uses Who uses tobacco: I certify that this inf will notify the plan- my medical records that providing false Employee's Signature	poption, if applicable, ent according to PEI reduction Authority ance Depen following statements seen explained to me, end by me in writing. The properties of the stobacco you were policy holds formation is correctly and the properties of such change to check my to information on re:	To add a dependent I LA rules. See your PE - I am enrolling for () dent Life Insurance (s s: and I decline to particiand I hereby accept th I understand that the I runderstand that the I runderstand that the I runderstand I hereby accept the I understand that the I runderstand that I runderstand that I runderstand that I runderstand that I runderstand I runder	to your health cover to your health cover he	erage, you must on Description for the above into one who prove	Rec Wife Daughter Daughter Daughter Daughter Other sy omplete a Change- details. Specify rel davit. If none insurance prer No tobac ges before the e orm that WVPF ormation is tru de false inform	pecify below** In-Status formationship: Date of the people in the peo	Husband Son Son Son Ny premium con ution. et the last six te of my cov gents have a et and under be prosecute	on your months months and constand ad.
*Date of Marriage or Ade *Must be eligible depende election, Acceptance and D	poption, if applicable, ent according to PEI reduction Authority ance Depen following statements seen explained to me, end by me in writing. The properties of the stobacco you were policy holds formation is correctly and the properties of such change to check my to information on re:	To add a dependent IA rules. See your PF I am enrolling for the see your PF and I decline to particular and I decline to particular and I decline to particular and I must be seen that the I runderstand the I	to your health cover to your health cover he	erage, you must on Description for y): Affidavit disign the affihealth and life di/or children) mustion changsigning this fe the above into see who provides the different provides the above into see who provides the different provides the above into see who provides the different provides the above into see who provides the different provide	Re Wife Daughter Daughter Daughter Daughter Other sy complete a Change-details. Specify rel above, and authorize of benefits or the am davit. If none insurance prer No tobace ges before the e comment of the work of the system.	In-Status formationship: Date of the people in the people	Husband Son Son Son Ny premium con ution. et the last six te of my cov gents have a et and under be prosecute	on your months rerage I cocess to total add.

Retired Employees Optional and Dependent Life Insurance Enrollment Form

Complete the Agency information at the bottom of the form.

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit number found on the monthly billing invoice.

OPT Plan: Use the option code below based on the plan chosen by the employee.

Retiree Plan Number	Option Code
Plan I	100
Plan II	200
Plan III	250
Plan IV	300
Plan V	400
Plan VI	500
Plan VII	600
Plan VIII	700
Plan IX	800
Plan X	900

Dep. Plan: Use the option code below based on the plan chosen by the employee.

Dependent Plan Number	Option Code
1	100
2	200
3	300
4	400

Please note that if documentation is required for a dependent and cannot be submitted with the enrollment application, the form on page 9 should accompany submission of the documentation to PEIA.

Date of Retirement: Enter the effective date of the employee's retirement

Effective Date of Coverage: Usually the same as the effective date of retirement. Coverage for retirees is continuous as long as forms are completed and signed during the retirement event enrollment period.

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you sign the form. Forms should be signed immediately upon receipt from the policyholder.

Forms 30 December 2010

State of West Virginia Public Employees Insurance Agency Surviving Dependents - Health Benefits Enrollment Form



Complete this form to enroll for or continue PEIA health insurance coverage as a surviving dependent.

Complete all sections of the form except the last section titled "AGENCY".

.	[w a .								
S D	Name (Last)	(First)	(MI)		(Generation)				
U E R P	Sex (Circle One) Date of Birt	th (MM/DD/YY) Social Security #		u previously been covered by PEIA? Other Insurance (Plan Name) If Any					
V E I N	Street Address				County of Resid	lence Home Pho			
V D I E	City	State				Work Pho			
N N	Deceased		Т	Date of Death	If you do not wis	h to participate in PEIA c		elow sion	
G T				Duic of Death	If you do not wish to participate in PEIA coverage, please indi and return this form to your insurance coordinator. I decline any PEIA coverage.		ordinator. I decline to part	ticipate in	
	Name:	SSN:		·	Signature:		YES		
F		d by any other health benefits plan for	-	ast three (3) months	? YES [□ №			
A M	I .	wing information: Insurance Compar n you were or when you will be entit		overage. Effective D	ate:	Term	ination Date		
I	If you are enrolling for family	survivor's health coverage, please coas a dependent by PEIA, please enter	omplete the follow	ving information for	all dependents who	will be covered under	your plan. If any of you	r depend-	
LY	cins were previously covered to	is a dependent by TEIA, piease enter		onship Sex/Category	Birth Date	loie unless previously c	Other Insurance		
ı	Name (Last, First, MI, Gene	eration) Address (If different fro			(MM/DD/YY)	Social Security #	(Plan Name)	Covg?	
N			SP	СН			<u> </u>		
F O			SP	СН					
R M			SP	СН					
AT			SP	СН					
I	CATEGORY for Dependent Child(ren):								
O N	y 2. Step-child 4. Court-Ordered Dependent Child 6. Other								
	In dependent column titled "	Sex/Category", please write (e.g., N	Al for Male Chile	d; F3 for Female G	randchild; F26 for	r Female Step-child/St	udent, etc.).		
	Please indicate the benefit plan	n for which you are enrolling:		Please indica	ate the type of PEL	A plan for which you as	e enrolling:		
C	1 Single Survivor's Health Coverage (no dependents)			PEIA Indemnity Plan					
v	2 Family Survivor's Health Coverage			2	Managed Care Plan Check Option if Applicable:				
E R				HMO POS					
A	The benefits have been evaluit	ned to me, and I hereby accept the for			1 -1 Y 1 4 -	Advad DEVA			
G E	benefits or the amount of cont	ribution. I hereby authorize release o	f all medical and	prescription informa	tion needed to proc	ess claims or review ut	ilization.	S 01	
	Applicant's Signature:					Date:			
	To Be Completed By Th	a Employer							
П	Agency Name	ie Employer:		Account Number	,	Region			
A	,			Trevount Trumout		Region			
G E	Effective Date of Coverage			Coverage Code Termination Date of Deceased Employee's Cover			overage		
N C	I hereby certify that this information is true and this surviving dependent meets the minimum eligibility requirements for the Public Employees Insurance Plan.								
Y	Authorized Signature: Date:								
	WHITE - PEIA YELLOW - Managed Care Plan PINK - Payroll Location GOLDENROD - Employee								
				,	•		,		

PEIA - 5005 Revised July 1998

Surviving Dependent Enrollment Form

Complete the Agency portion at the bottom of this form.

Agency Name: Your agency name as it appears on your PEIA monthly billing.

Account Number: Your 9-digit number found on the monthly billing invoice.

Region: No longer required on the Surviving Dependent Enrollment Form.

Effective date of Coverage: When completing the form, enter the first day of the month following date of enrollment (the date the survivor signs the forms to elect the coverage).

Coverage Code: Please use one of the codes below to indicate the survivor's plan:

HI01 PEIA PPB Plan A

HMHP - A Health Plan HMO Plan A HMHP - B Health Plan HMO Plan B

Remember that the survivor has to continue coverage in whichever plan he or she was in at the time of the policyholder's death. The survivor will pay the same premium as a retiree with 25 or more years of service. Another choice can be made during the next open enrollment

Enter one of the following letters beside the Coverage Code to show the tier of coverage the employee has selected:

P = Survivor Only

C = Survivor and Children Only

A completed Coverage code could look like this: **HI01 – P**, or like this: **HMHP-B-C**.

Remember that survivors are not eligible for life insurance.

Termination Date of Deceased Employee's Coverage: This date should be the last day of the calendar month in which the employee died. If the employee died on January 1st, the termination date would be January 31st.

Authorized Signature: Your signature as the Benefit Coordinator.

Date: The date you sign the form. Forms should be signed immediately upon receipt from the survivor.

Forms 32 December 2010

The forms on the following pages are not specifically for use by Benefit Coordinators, and do not require the Benefit Coordinator's signature. We are including them in this book for your convenience and reference.

Forms included here are:

Combining of Accrued Sick and/or Annual Leave form Request for Refund of Premium Beneficiary Statement (Minnesota Life)

Forms 33 December 2010

State of West Virginia Public Employees Insurance Agency

COMBINING OF ACCRUED SICK AND/OR ANNUAL LEAVE

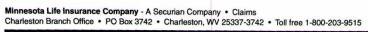
Spouse's NameSpouse's Social Security No	Spouse's Agency NameSpouse's Agency Account No				(Signature) (Day)
Retired Employee's Name	Retired Employee's Agency Name	Please indicate which retired employee will carry the:	Basic Life Insurance Only* (Name)	surance whi be aeauctea fron	(Signature) (Day)

8.24.98/trs

West Virginia Public Employees Insurance Agency						
REQUEST FOR REFUND OF PREMIUM						
TO WHOM SHOULD THIS REFUND BE ISSUED?	SSN OR FEIN:					
TO WHAT ADDRESS SHOULD THIS REFUND BE SENT?						
UNDER WHICH ACCOUNT NUMBER WAS THE OVERPAYME	INT MADE?					
IN WHICH MONTH(S) WAS THE OVERPAYMENT MADE?						
PLEASE INDICATE THE TOTAL PAYMENTS MADE FOR THIS	EMPLOYEE/RETIREE DURING THIS PERIOD:					
TELASE INDICATE THE TOTAL LATMENTS MADE FOR THIS	EMI LOTEL/RETIRLE DURING THIS TERIOD.					
EMPLOYER CONTRIBUTION: EMPLOYER	E/RETIREE CONTRIBUTION:					
TOTAL REFUND DUE FOR THE MONTH(S) LISTED ABOVE:						
\$						
PLEASE EXPLAIN IN DETAIL WHY A REFUND IS BEING REQ	UESTED:					
	D.A. MIT					
AUTHORIZED SIGNATURE:	DATE:					
THIS FORM MUST BE COMPLETED AND SIGNED BY THE BEI	NEFIT COORDINATOR OR PAYROLL OFFICER					

Forms 35 December 2010

Beneficiary Statement





PART 1 – All fields must be com Name of deceased (last, first, middle in		uding your	signature	Policy number		CLAIM NUMBER	
				33227			
Other names by which the deceased I	has been known, if any						
Address prior to death (street, city, sta	ite, zip)						
Date of birth (mo/day/yr)			Date of deat	h (mo/day/yr)			
Name of beneficiary (last, first, middle	initial)						
Relationship to deceased				Beneficiary's date of birth			
CERTIFICATION INSTRUCTION to backup withholding because of	NS: You must cross of underreporting inte	out item (2) erest or divid	below if you lends on you	have been not ur tax return.	ified by the I	RS that you are subject	
CERTIFICATION - Under Penal	lties of perjury, I cert	ify that:					
 The number shown on this f I am not subject to backup v that I am subject to backup me that I am no longer subject I am a U. S. person (including) 	withholding either be withholding as a resi ect to backup withhol	cause I have ult of a failure ding, and	e not been r	otified by the li	nternal Reve	nue Service (IRS)	
CERTIFICATION NOTICE: The number. Without this information death benefit.							
Signature of beneficiary			Date		Beneficiary's	s Social Security number	
Address of beneficiary (street, city, sta	ate, zip)				Telephone r	number of beneficiary	
Signature of witness					Date signed		
X Address of witness (street, city, state,	zip)				1		
A CERTIFIED C	OPY OF THE PUBL	IC DEATH I	RECORD IS	REQUIRED A	S PROOF C	OF DEATH	
PART 2 - PAYMENT INFORMATI		sent to you	via a check	c if Part 2 is no	t fully compl	eted and signed.)	
How would you like to receive the pro-		ust complete	and sign the b	ottom of this form			
Authorization for Direct Depo I authorize Minnesota Life Insur adjust any deposits made in err to accept these deposits and/or This authorization is to remain i such time and manner as to affeterminates this method of paym	ance Company ("Co or to my account ind corrections made to n full force and effec ord Company and De	licated below this accour t until Comp	v. I authoriz nt. any has rec	e the financial eived written n	institution ("I otification fro	Depository") named below om me of its termination in	
Name of depository (bank, credit unio	on, etc.)			Depository	Depository telephone number		
Street			City		State	Zip code	
Account type Savings Checking	Bank routing/transit nu	mber		Account num	ber		
IMPORTANT: For purposes of ac Signature of beneficiary	curacy, PLEASE ATT	ACH A VOID	DED CHECK	OR SAVINGS	Date signed		
X					Date signed	*	
PART 3 - NOTICE							
For your protection, state law fraudulent claim for the paymen insurance company or agent of to a settlement or award payable F5562-PEIA Rev 11-2010	t of a loss is guilty of an insurance compa	f a crime and any who kno	d may be su wingly atten	ibject to fines a npts to defraud	nd confinem a policyhold	ent in state prison. Any ler or claimant with regard	

Forms 36 December 2010